

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING Division of Licensing and Protection

103 South Main Street, Ladd Hall Waterbury VT 05671-2306

Waterbury VT 056/1-2306 http://www.dail.vermont.gov

Voice/TTY (802) 241-2345

To Report Adult Abuse: (800) 564-1612

Fax (802) 241-2358

March 25, 2010

Dane Rank, Administrator Thompson House Nursing Home 80 Maple Street Brattleboro, VT 05302

Provider #: 475050

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the revisit survey conducted on **March 9**, **2010**. Please post this document in a prominent place in your facility.

We will follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Suzanne Leavitt, RN, MS

Disability and Aging Services

Sezanne E. Louth Ru, ms

Licensing Chief

Enclosure



THA NU. BUZZ412300

#1594 P.003/009

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/22/2010 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		INTENTIFICATION NUMBER		COM	X3) DATE SURVEY COMPLETED	
		B. WING	R 3/09/2010			
	Provider or supplier Son House Nursi		80	EET AODRESS, CITY, STATE, ZIP CODE O MAPLE STREET RATTLEBORO, VT 05302		
(X4) ID PREFIX TAG	MACH DEFICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
{F 000}	INITIAL COMME	NTS	{F 000}			
(F 329) SS=D	recertification sur Division of Licens 483.25(I) DRUG I UNNECESSARY Each resident's dunnecessary drug drug when used i duplicate therapy without adequate indications for its adverse consequeshould be reduce combinations of the same o	onsite re-visit to the annual vey was conducted by the ing and Protection on 3/9/10. REGIMEN IS FREE FROM DRUGS Trug regimen must be free from as, An unnecessary drug is any in excessive dose (including is); or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose of or discontinued; or any increasive assessment of a ty must ensure that residents of antipsychotic drugs are not unless antipsychotic drug ary to treat a specific condition of documented in the clinical ents who use antipsychotic dual dose reductions, and intions, unless clinically in an effort to discontinue these	{F 329}	Resident #1's medications were reviewed and clarified, to include route of administration, parameters for use, and indications for use. Duplicate medication order was corrected. MAR's (Medication Administration Records) were audited for all residents to ensure route of administration, parameters for use, indications for use, and appropriate orders are in place. Policies regarding Physician Orders were reviewed and updated as necessary. DNS/SDC will provide education to all nursing staff regarding Physician Orders	3/24/10 3/24/10 3/26/10 3/26/10	
	This REQUIREME by: Based on interview	ENT is not met as evidenced wand record review, the facility		policy. DNS or designee will audit 5 resident records each quarter to ensure that Physician orders are complete and accurate. Results will be reported at QA meetings. DNS to monitor	Ongoing	
	free from unneces Findings include:	of 3 residents' drug regimen is sary drugs (Resident #8).		for compliance. P.D.C. Accepted 3/24/10 Paintin CotaRN TITLE	(XB) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the data these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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#1594 P.004/009 T. UD

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
475050		B. WING _	B. WING			
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME			a	REET ADDRESS, CITY, STATE, ZIF 10 MAPLE STREET 3 RATTLEBORO, VT 05302	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IQ PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XŠ) COMPLETION DATE
(F 329)	Continued From pa	ge 1	(F 329)			
	Per record review or regimen contains modoses, as well as a Two of the following adequate indication resident were identiannual recertification 1/7/10. The most reference following orders: 1. Morphine 15 mg following orders: 2. Morphine 15 mg following orders: 2. Morphine 15 mg following and 3/10, both since 2/11/10. 2. Benadryl 25 mg following for use of the total orders order	n 3/9/10, Resident #1's drug sedications that have variable duplicate medication order. In medications lacking is for use for this same fied and cited during the in survey, completed on cent physician orders for lon 2/19/10, contained the tab 1-2 tabs (15-30 mg) by it is as needed for severe pain, ations for when to give 1 medication. Per review of in Administration Record) for doses of Morphine were used -2 caps (25-50 mg) by mouth eded. There were no if the medication or for when his, cate orders for Miralax 17 yy. Per review of the MAR for esident received one dose to a 3/9/10 at 1:32 PM, the ring) confirmed that the dryl orders had not been				
	were duplicate order	, and confirmed that there s for Miralax.				
{F 387} SS≃D	Refer also to F520. 483.40(c)(1)-(2) FRE OF PHYSICIAN VISI	QUENCY & TIMELINESS T	(F 387)		, !	
	The resident must be once every 30 days f	s seen by a physician at least or the first 90 days after				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Statement of Deficiencies and Plan of Correction		(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED	
		475050	B. WING		03	R /09/2010	
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ŜŢĘ	REET ADDRESS, CITY, STATE, ZIP CO	*	103/2010
THOMPS	ON HOUSE NURSING	HOME		8	MAPLE STREET BRATTLEBORO, VT 05302	, r =	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)	PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	n should be	COMPLETION PATE
{F 387}	1	ge 2 east once every 60 days	{F 3	87}	F 387		3/19/10
	A physician visit is o	considered timely if it accurs				Resident #25 was seen by the Physician for required visit. Resident #50 was seen by the Physician for required visit.	
,.	not later than 10 da required. 	ys after the date the visit was					
This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 2 of 3 residents (#25, #50)				Resident #25 and 50's Ph were provided a copy of t requirement for frequency Physician Visits.	fthe	3/15/10	
	were seen by the physician at the required intervals after admission. Findings include: 1. Per record review on 3/9/10, Resident #25 was not seen every 30 days for the first 90 days after admission to the facility on 11/12/09. Resident #25 was cited during the annual recertification survey, completed 1/7/10, for not receiving				Administrator met with R #25 and 50's Physicians t explain necessity of comp with Federal Regulations order to continue to followersidents in this facility.	o oliance in	3/26/10
	required physician v correction, the resid on 1/9/10. Since the been no further visit	ed physician visits. As part of the plan of ction, the resident was seen by the physician 1/10. Since that visit on 1/19/10, there have no further visits by the physician, making			All resident records were reviewed to ensure timely Physician visits are comp	1	3/26/10
	Resident #25 would 2/12/10. Per staff in	the first 90 days of admission. would be due for a physician visit by staff interview, the ONS verified on that there was no evidence of a			DNS or designee will aud records each quarter to en timely Physician visits an	isure that e completed.	Ongoing
	Refer also to F520.				Results will be reported a QA meetings. DNS to m for compliance.	nonitor	Ongoing
	physician progress r dated 11/19/09. Phys #50 have not been s staff interview, the D	on 3/9/10, the last signed lote for Resident #50 was sician orders for Resident igned since 11/18/09. Per ON verified, on 3/9/10 at was no evidence of a 11/19/09.			P.D.C. Accepted 3/24/10 Pameler Moter) W	

#1594 P.006/009 F. UI

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X4) (X4) PROVIDER/SUPPLIE	(X3) DATE SURVEY COMPLETED	
475050 B. WING	R 03/09/2010	
NAME OF PROVIDER OR SUPPLIER THOMPSON HOUSE NURSING HOME STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE STREET ERATTLEBORO, VT 05302	45/49/50 12	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOUL) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRO	JLD BE COMPLETION	
F 428 SS=D RREGIMEN REVIEW, REPORT RESIDENCE RESIDENCE RESIDENCE RESIDENCE RESIDENCE RESIDENCE RESIDENCE RESIDENCE Resident #1's medications were reviewed and clarified, to include route of administration, parameters for use, and indication for use. Duplicate medication order was corrected. MAR's (Medication Administration Records) were audited for all residents to ensure route of administration, parameters for use, and indication order was corrected. MAR's (Medication Administration Records) were audited for all residents to ensure route of administration, parameters for use, indications for use, and appropriate orders are in place. MAR's (Medication Administration Records) were audited for all residents to ensure route of administration, parameters for use, indications for use, and appropriate orders are in place. Administrator and Director of Nursing met with consulting Pharmacist failed to identify irregularities in the drug regimen of 1 of 4 residents (Resident #8). Findings include: Per record review an 3/9/10, the consulting pharmacist failed to identify that Resident #1's drug regimen contains a medication that has a variable dose, as well as a duplicate medication order. The most recent physician orders, signed on 2/19/10, contained the following orders: Morphine 15 mg tab 1-2 tabs (15-30 mg) by mouth every 4 hours as needed for severe pain. There were no indications for when to give 1 versus 2 tabs of the medication. Per record review and interview, the consulting Pharmacist recommendations have been addressed as appropriate. DNS or designee will audit all Pharmacist recommendations monthly to ensure all have been addressed as appropriate. DNS or designee will audit all Pharmacist recommendations have been addressed as appropriate. DNS or designee will audit all Pharmacist recommendations monthly to ensure all have been addressed as appropriate. DNS or designee will audit all Pharmacist recommendations monthly to ensure all have been addressed as	de 3/24/10 ons 3/26/10 3/26/10 de	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		475050	8. WING		03/09/2010
	ROVIDER OR SUPPLIER SON HOUSE NURSING	3 HOME	\$.	TREET ADDRESS, CITY, STATE, 2IP C 80 MAPLE STREET BRATTLEBORO, VT 05302	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	IN SHOULD BE COMPLETION DATE
	Per review of the plant the consultant phant seek clarification of Morphine without in the duplication of the 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLANT A facility must maint assurance committee nursing services; a facility's staff. The quality assess a facility's staff. The quality assess acommittee meets at issues with respect and assurance active develops and impler action to correct ideal assurance active develops and impler action to correct ideal assurance of the recept insofar as sucompliance of such requirements of this Good faith attempts and correct quality da basis for sanctions. This REQUIREMENT by: Based on interview a	narmacy consults since if 1/09, macist failed to identify and the variable dose for dications, and failed to identify e Miralax order. BERS/MEET IS tain a quality assessment and se consisting of the director of physician designated by the 3 other members of the least quarterly to identify to which quality assessment ities are necessary; and ments appropriate plans of ntified quality deficiencies. etary may not require ords of such committee committee with the section. by the committee to identify efficiencies will not be used as	{F 428	See next pa	as were 3/9/10 sinclude 3/24/10 include 3/24/10 include 3/24/10 indications eation 3/26/10 indications orders 3/26/10 indications orders at 3/26/10 indications orders at Ongoing insure that inplete and include 3/26/10 incl
	during the annual rec	certification survey,		tot omittamen.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		1,	LTIPLE CONSTRUCTION	(X3) DATE COMPI	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		•	R			
,		476050		B. WING		03/	09/2010	
i	ROVIDER OR SUPPLIER	3 HOME		5	TREET ADDRESS, CITY, STATE, ZIP 1 80 MAPLE STREET BRATTLEBORO, VT 06302	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	on should be te appropriate	COMPLETION DATE	
F 520	completed 1/7/10, f (Resident #1, #25). 1. Per record review drug regimen conta variable doses, as worder. Two of the following resident were identification resident were identification annual recertification 1/7/10. The most recon 2/19/10, contain a. Morphine 15 mg mouth every 4 hour There were no indictiversus 2 tabs of the the MAR (Medication 2/10 and 3/10, both since 2/11/10. b. Benadryl 25 mg every 6 hours as ne indications for use to give 1 versus 2 to c. There were duplications for use to give 1 versus 2 to c. There were duplications for use to give 1 versus 2 to c. There were duplicated and 3/10, the result of the fact were duplicated or clarified were duplicated o	or 2 applicable residents Findings include: y on 3/9/10, Resident #1; ins medications that have well as a duplicate medications lack s for use for this same filed and cited during the in survey, completed on a cent physician orders; tab 1-2 tabs (15-30 mg) is as needed for severe p cations for when to give 1 medication. Per review on Administration Record doses of Morphine were 1-2 caps (25-50 mg) by in medication or for w abs. Icate orders for Miralax 1 illy. Per review of the MA esident received one dos ate order was not on 3/9/10 at 1:32 PM, the dursing) confirmed that the dryl orders had not been d, and confirmed that the dryl orders had not been d, and confirmed that the	ention en	F 52	The results of the Plan of Correction compliance a audits will be discussed weekly by the Administ and the Director of Nurse Results will be reported QA meetings. DNS to a compliance. P.D.C. Accepted 31 Camela Mutal	and rator sing. at nonitor for	Ongoing 3 26 10 Ongoing	

THX NU. BUZZ412358

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CIJA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ſ	MULTIP	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475050	. B' A	VING		R 03/09/2010	
	ROVIDER OR SUPPLIER	į		80	et address, city, state, zip Maple street Mattleboro, VT 05302		
(X4) ID PREFIX TAG	(EACH DEPICIENC	Atement of Deficiencies by Must be preceded by Full LSC (Dentifying (Nformation)	PRE	Fix \G	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TE DEFICIENCY	on should be He appropriate	COMPLETION GATE
F 520	correction, the res on 1/9/10. Since to been no further visionly 1 visit in the fi Resident #25 wou. 2/12/10. Per staff in	visits. As part of the plan of ident was seen by the physicinat visit on 1/9/10, there have sits by the physician, making ret 90 days of admission did be due for a physician visit nterview, the DNS verified or there was no evidence of a	ian e	520	DEFILIENC		
	<u></u>						